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Non-delegable duties and institutional liability for the negligence of hospital staff: Fair, just and reasonable?

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1. Introduction

Identifying the existence of a 'duty of care' is fundamental to the tort of negligence. Yet, as Keith Stanton recognised in this journal recently, this element of professional negligence liability remains shrouded in doubt.¹ Stanton, in particular, has been critical of resort to the 'ultimately vague test' of whether it is 'fair, just and reasonable' to impose a duty of care on the particular facts (as advocated by *Caparo Industries plc v Dickman*²) and, notably in the context of pure economic loss and omissions cases, to the 'vague, and meaningless, formula' of voluntary assumption of responsibility.³ The former, in particular, draws the courts into policy decisions in which they must identify the correct balance between distributive and corrective justice.⁴ Cases such as *Caparo* and later *Customs & Excise Commissioners v Barclays Bank*⁵ highlight the increasing emphasis of the highest UK court on policy factors in determining when a duty of care should arise in negligence.⁶

A new edition of Stanton's celebrated text - *Dugdale and Stanton on Professional Negligence*⁷ - would face a further challenge to negligence liability: the rise of the *non-delegable* duty of care. In 2013 the Supreme Court in *Woodland v Essex CC*⁸ established a framework for the imposition of non-delegable duties of care on institutions such as schools and hospitals which have assumed personal responsibility for the welfare of particular classes of persons in circumstances where it would be 'fair, just and reasonable' to impose liability. While *Woodland* itself concerned the liability of schools to their pupils, the Court made it clear that it would extend beyond this context. Lord Sumption, in particular, made express reference to claimants who were patients under the care of medical institutions and drew on authorities discussing non-delegable duties in relation to such claims. While much has been written about *Woodland* itself,⁹ in this article I will explore the impact of *Woodland* on hospital liability and the role which - what I will call the 'hospital non-delegable duty' - will play in claims for clinical negligence. As will be seen, this particular non-delegable duty has had a troubled history - not least due to the fact that its main advocate was a certain Lord Denning in *Cassidy v Ministry of Health*.¹⁰ The hospital non-delegable duty was suggested in the 1940s,

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¹ K Stanton, 'Defining the duty of care for bank references' (2016) 32 PN 272.

² [1990] 2 AC 605.

³ Stanton (n 1) 274.

⁴ *White v Chief Constable of South Yorkshire* [1999] 2 AC 455, 510-511 per Lord Hoffmann; *McFarlane v Tayside Health Board* [2000] 2 AC 59, 83 per Lord Steyn.

⁵ [2006] UKHL 28, [2007] 1 AC 181.

⁶ See J Morgan, 'The rise and fall of the general duty of care' (2006) 22 PN 206.

⁷ See AM Dugdale and KM Stanton, *Professional Negligence* (3rd edn, Butterworths, 1998).

⁸ [2013] UKSC 66, [2014] AC 537.

⁹ Including my own work in this journal: P Giliker, 'Vicarious liability, non-delegable duties and teachers: can you outsource liability for lessons?' (2015) 31 PN 259. See also R George, 'Non-delegable duties of care in tort' (2014) 130 LQR 534 and J Morgan, 'Liability for independent contractors in contract and tort: Duties to ensure that care is taken' [2015] CLJ 109.

¹⁰ [1951] 2 KB 343, 362-363 (then Denning LJ).

and then all but abandoned subject to certain obiter dicta from the late 1980s. In *Woodland*, however, Lord Sumption confirmed the correctness of Lord Denning's reasoning in *Cassidy*.¹¹ With reference to Stanton's work, this article will critically appraise the application of the *Woodland* test to clinical negligence claims and consider its relationship with existing forms of liability, namely primary liability for fault and vicarious liability for the torts of employees in the course of their employment. When then, following *Woodland*, will it be 'fair, just and reasonable' to impose a non-delegable duty of care on hospitals towards their patients?

2. Identifying the need for non-delegable duties in tort law.

Before examining the *Woodland* test and the hospital non-delegable duty, it is important first to ascertain the role of non-delegable duties in the law of tort. Non-delegable duties remain a somewhat curious feature of the law of tort. Contrary to the ordinary fault principle, they render the defendant *personally* liable for breach even where performance of the duty in question has been delegated to another.¹² This 'other' may be an employee or an independent contractor. 'Personal' liability is therefore to be taken broadly – the defendant remains liable even though the immediate cause of the damage is not the defendant's wrongful act or omission, but that of the delegate. It is thus not simply a duty to take care, but a duty *to ensure that care is taken*.¹³ Lord Sumption openly recognised in *Woodland* that this is unusual:

'The law does not in the ordinary course impose personal (as opposed to vicarious) liability for what others do or fail to do ... The expression "non-delegable duty" has become the conventional way of describing those cases in which the ordinary principle is displaced and the duty extends beyond being careful, to procuring the careful performance of work delegated to others.'¹⁴

Such duties are not, however, confined to negligence: liability may, depending on the nature of the non-delegable duty in question, be strict or fault-based. However, if the latter, the net result is that the defendant is liable for negligence, committed by herself or another, even if that other is an independent contractor. It is distinct, however, as Lord Sumption indicates above, from the doctrine of vicarious liability which, orthodox theory dictates, imposes secondary, not primary, liability.

As might be imagined, this is contentious. It is difficult to discern a clear distinction between the non-delegable duty and vicarious liability on a functional analysis in that both concepts render the employer liable in tort for the tortious actions of another. In rendering an employer (X) liable for the torts of the person to whom he delegated his duty of care, are we not imposing strict liability for the torts of another, in other words, vicarious liability?¹⁵ Further, non-delegable duties have arisen in such a variety of contexts that it seems impossible to identify a single conceptual basis capable of uniting all forms of such duty.

¹¹ *Woodland* (n 8) para 23.

¹² MA Jones (ed), *Clerk and Lindsell on Torts* (21st edn, Sweet and Maxwell, 2014) para 6-60.

¹³ *The Pass of Ballater* [1942] P 112, 117 per Langton J.

¹⁴ *Woodland* (n 8) para 5, adding 'The expression "non-delegable duty" has become the conventional way of describing those cases in which the ordinary principle is displaced and the duty extends beyond being careful, to procuring the careful performance of work delegated to others.'

¹⁵ See Morgan (n 9); J Morgan, 'Vicarious liability for independent contractors?' (2015) 31 PN 235-258.

Indeed, examination of any academic or practitioners' text prior to 2013 would merely provide the reader with a list of occasions in which non-delegable duties have arisen with little attempt to find a single overall rationale.¹⁶ Such duties, for example, vary from liability for the escape of substances likely to do mischief (*Rylands v Fletcher*¹⁷) to liability for inherently hazardous activities (*Honeywill v Larkin*,¹⁸ highlighting the dangers of taking photographs in theatres in the 1930s!) to liability for dangers on the public highway¹⁹ to employer liability to its employees²⁰ to liability arising from duties laid down by statute.²¹ Glanville Williams, a notable critic of non-delegable duties, commented famously that 'the cases are decided on no rational grounds, but depend merely on whether the judge is attracted by the language of non-delegable duty'.²²

While commentators have inevitably argued how to explain the theoretical basis for such duties (and reconcile their diverse nature),²³ the reality has always been that non-delegable duties are essentially gap-fillers. They allow the courts for reasons of policy to impose liability on a defendant when the more straight-forward action in tort, be it negligence, nuisance or trespass, is not available.²⁴ They are a device – a strategy – to circumvent the limits of existing causes of action and must, logically, be distinct from vicarious liability because they are relied upon to circumvent the limits of this doctrine as well. On this basis, where the courts are unable to find a relationship giving rise to vicarious liability (the 'no employee' problem) or find that the act is not performed in the course of employment (the 'course of employment' problem), then the non-delegable duty may provide the only means to impose liability on an employer.²⁵

A closer examination of the list of non-delegable duties provides immediate support for the 'non-delegable duty as gap-filler' argument. The employer's non-delegable duty arose to

¹⁶ See, for example, the 20th edition of MA Jones (ed), *Clerk & Lindsell on Torts* (20th edn, Sweet and Maxwell, 2010) which considered (at para 6–56) that 'no general principle can be stated and ... the various types of case must be dealt with individually.'

¹⁷ (1866) LR Exch 265; aff'd (1868) LR 3 HL 330.

¹⁸ [1934] 1 KB 191.

¹⁹ *Holliday v National Telephone Co* [1899] 2 QB 392.

²⁰ *Wilsons and Clyde Coal Co Ltd v English* [1938] AC 57.

²¹ e.g. in *Smith v Cammell Laird and Co Ltd* [1940] AC 242, the House of Lords held that the duty imposed on the occupier of a shipyard by the Shipbuilding Regulations 1931 to ensure that all staging was secure, sound and properly maintained was an absolute duty, so that the occupier was liable when a contractor removed the lashing from some staging, causing injury to the plaintiff.

²² G Williams, 'Liability for Independent Contractors' [1956] CLJ 180, 186.

²³ In addition to Williams above, see J Murphy, 'Juridical foundations of common law non-delegable duties' and R Stevens, 'Non-delegable duties and vicarious liability' in J Neyers, E Chamberlain and S Pitel, *Emerging Issues in Tort Law* (Hart, 2007); C Witting, 'Breach of the non-delegable duty: Defending strict liability in tort' (2006) 29 UNSWLJ 33 and J Murphy, 'The liability bases of common law non-delegable duties – A reply to Christian Witting' (2007) 30 UNSWLJ 86.

²⁴ This is acknowledged, for example, by Lord Phillips MR in *A (A Child) v Ministry of Defence* [2004] EWCA Civ 641, [2005] QB 183, para 30; Dyson LJ in *Farraj v King's Healthcare NHS Trust* [2009] EWCA Civ 1203, [2010] 1 WLR 2139, para 74; Lady Hale in *Woodland v Essex CC* (n 8) para 36.

²⁵ The non-delegable duty seems, however, to have been used primarily in the former situation. In *Lister v Hesley Hall* [2001] UKHL 22, [2002] 1 AC 215, for example, only Lord Hobhouse (para 55) seems to have regarded the non-delegable duty as a means of circumventing the 'course of employment' problem, while the rest of the court focussed on expanding the doctrine of vicarious liability.

allow claims otherwise blocked by the doctrine of common employment (by which the employer could not be held vicariously liable to employees injured due to the negligence of their fellow employees).²⁶ Difficulties in bringing the claim under the embryonic tort of negligence or the tort of private nuisance were resolved in *Rylands v Fletcher*.²⁷ Fundamentally, the courts were aware that the limits of the doctrine of vicarious liability could be avoided by providing an alternative claim based on a non-delegable duty, as seen in cases such as *Cassidy v Ministry of Health*,²⁸ discussed below. The non-delegable duty exists, therefore, as a tool in the armoury of the pursuit of social justice. It is, however, a tool, as Glanville Williams pointed out in 1956, which does not necessarily bear close scrutiny in terms of conceptual clarity or judicial basis.²⁹

It remains an awkward question what should happen to the non-delegable duty once the obstacle to the more straightforward form of liability is removed. One might question, for example, the continued need for the employer's non-delegable duty when the gap *Wilsons and Clyde Coal* sought to fill had been removed by the abolition of the doctrine of common employment in 1948.³⁰ Similarly the rule in *Rylands v Fletcher* has managed to survive despite changes in the tort of private nuisance into which it has now been absorbed (and indeed the subsequent growth of the tort of negligence).³¹ Judges appear reluctant to remove rights to sue and, as a result, once created, non-delegable duties prove resilient to change. Such conservatism, while perhaps understandable, does serve to diminish whatever integrity the non-delegable duty may claim to possess as it loses its *raison d'être* and yet remains within the legal system. It does explain, however, how non-delegable duties have survived despite the expansion of vicarious liability during the twentieth and twenty-first century, including its recent extension to cover tortfeasors 'akin to employees' (who would have previously been dismissed as independent contractors)³² and the adoption of a very broad interpretation of the course of employment test.³³

The decision of the Supreme Court in 2013 to create a new non-delegable duty logically rests therefore on the view that there is a gap here to be filled. What is important about this case, however, is that the Court used its decision in *Woodland* to provide a rationalisation of non-delegable duties generally, creating a broad category of claims based on a positive

²⁶ Laid down in *Priestley v Fowler* (1837) 3 M & W 1; 150 ER 1030. See MA Stein, 'Priestley v Fowler (1837) and the emerging tort of negligence' 44 BCL Rev 689 (2003).

²⁷ See FH Newark, 'The Boundaries of Nuisance' (1949) 65 LQR 480.

²⁸ [1951] 2 KB 343.

²⁹ See n 22.

³⁰ Law Reform (Personal Injuries) Act 1948, s.1. See Morgan (n 15) at 237-238: 'It is a mystery why judges who openly admit that "non-delegability" was an evasion of common employment have not drawn the conclusion that it is here quite obsolete.' It can be argued, nevertheless, that courts are likely to be reluctant to be seen to reduce employee protection against industrial injuries.

³¹ See *Transco plc v Stockport MBC* [2003] UKHL 61, [2004] AC 1. In any event, the tort of private nuisance, in contrast to the uncertainty existing at the time of *Rylands*, can now be interpreted as extending to one-off escapes of 'mischievous' substances: see, for example, *Crown River Cruises Ltd v Kimbolton Fireworks* [1996] 2 Lloyd's Rep. 533.

³² *JGE (or E) v English Province of Our Lady of Charity* [2012] EWCA Civ 938, [2013] 1 QB 722.

³³ *Mohamud v Wm Morrison Supermarkets Plc* [2016] UKSC 11, [2016] AC 677

assumption of responsibility towards the victim in question. This will be examined in more detail below.

3. Non-delegable duties and *Woodland*: A new framework for 'personal' liability.

In *Woodland*, Lord Sumption divided non-delegable duties into two broad categories. The first (which was not relevant to the case) consists of a large, varied and anomalous class of cases involving inherently hazardous activities and dangers on the public highway.³⁴ The second involves situations where the law has imposed a *positive* duty on a defendant to protect victims against a particular class of risks. The second category - into which the hospital non-delegable duty would fall – is characterised by three essential elements:³⁵

1. There is an antecedent relationship between the defendant and the claimant.
2. It imposes a positive or affirmative duty to protect a particular class of persons against a particular class of risks, and is not simply a duty to refrain from acting in a way that foreseeably causes injury.
3. The duty is by virtue of that relationship *personal* to the defendant. The work required to perform such a duty may well be delegable, and usually is. But the duty itself remains that of the defendant.

In framing the second category of non-delegable duty, Australian authority proved influential,³⁶ notably that imposing such a duty on schools³⁷ and employers.³⁸ The Court, in particular, took note of the words of Mason J in *Kondis v State Transport Authority*³⁹:

‘ ... it appears that there is some element in the relationship between the parties that makes it appropriate to impose on the defendant a duty to ensure that reasonable care and skill is taken for the safety of the persons to whom the duty is owed ... *In these situations the special duty arises because the person on whom it is imposed has undertaken the care, supervision or control of the person or property of another or is so placed in relation to that person or his property as to assume a particular responsibility for his or its safety, in circumstances where the person affected might reasonably expect that due care will be exercised*’.⁴⁰

³⁴ It might be argued that this is less a category than a collection of unresolved instances of non-delegable duties which do not fit into category two. It would seem that even Lord Sumption was unable to find one rationale to unite all existing non-delegable duties.

³⁵ *Woodland* (n 8), para 7.

³⁶ The Australian cases were described as ‘reasoned analyses of principle of high persuasive authority’ in the earlier case of *A (A Child) v Ministry of Defence* [2004] EWCA Civ 641, [2005] QB 183, para 43 per Lord Phillips MR. See also Dyson LJ in *Farraj v King's Healthcare NHS Trust* [2009] EWCA Civ 1203, para 85. Grubb argues that the non-delegable duty remained of use in Australia due to different contractual arrangements between doctors and institutions in that country: A Grubb, ‘Negligence: Direct liability and non-delegable duty’ (1998) 6 Med L Rev 376, 377.

³⁷ See *Commonwealth of Australia v Introvigne* (1982) 150 CLR 258 and *New South Wales v Lepore* (2003) 212 CLR 511: a school would owe a non-delegable duty to its pupils to take care in respect of their care and supervision.

³⁸ *Kondis v State Transport Authority* (1984) 154 CLR 672. See also *Burnie Port Authority v General Jones Pty* (1994) 179 CLR 520 (non-delegable duty owed by occupier of land).

³⁹ (1984) 154 CLR 672, 686-687 (emphasis added), cited in *Woodland* (n 8) at para 19.

⁴⁰ *Kondis* specifically refers to the example of the hospital which undertakes the care, supervision and control of patients who are in special need of care: *loc cit*.

This approach, described as ‘broadly correct’ by Lord Sumption,⁴¹ provides a specific policy rationale for the non-delegable duty: the non-contractual assumption of responsibility. This exists in parallel to the duty owed by a contracting party to perform the contractual services with reasonable care and skill. Where this duty is breached, the claimant in a contractual relationship with the defendant will be able to bring a claim for breach of contract regardless of the status of the individual the defendant employed to do the work. This becomes important in the context of institutions such as schools and hospitals where education or care may be supplied by private or public providers. Indeed, the Court in *Woodland* sought to avoid being seen to discriminate between victims injured in private and state schools.⁴² While paying school or hospitals fees will entitle the claimant to a contractual claim for any failure of the defendant to provide services performed with reasonable care and skill, this would now be mirrored in the law of tort so as not to deprive those with limited means of similar protection.⁴³ The reason, however, that this is an issue in *Woodland* is because institutions such as school and hospitals are now outsourcing key services. By delegating performance of tasks to private contractors, outsourcing means that claimants can no longer rely on the doctrine of vicarious liability. Personnel whose torts would previously have given rise to a claim for vicarious liability are now classified as ‘independent contractors’ leaving claimants at the mercy of the independent contractors’ insurance arrangements.⁴⁴ The assumption of responsibility non-delegable duty thus operates to fill the gap created by outsourcing. Hiring an independent contractor instead of an employee to perform your core tasks (e.g. teaching or caring for patients) will no longer allow the employer to avoid liability.

On this basis, Lord Sumption identified, at paragraph 23, five defining features characterising what we will now call the *Woodland* non-delegable duty:

1. The claimant is a patient or child (or for other reason especially vulnerable or dependant on the defendant’s protection against the risk of injury).
2. There is a pre-existing relationship between the claimant and the defendant independent of the negligent act or omission itself (i) which places the claimant in the actual custody/charge/care of the defendant and (ii) from which it is possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm.
3. The claimant has no control over how the defendant chooses to perform its obligations.

⁴¹ *Woodland* (n 8), para 23. See, generally, N Foster, ‘Convergence and divergence: The law of non-delegable duties in Australia and the United Kingdom’ in A Robertson and M Tilbury, *Divergences in Private Law* (Hart, 2016) at 119.

⁴² Note, in particular, the views of Lady Hale in *Woodland*. This echoes the statement of Lord Denning in *Cassidy* (n 28) at 359: ‘Clearly, if he is a paying patient, paying them directly for their treatment of him, they must take reasonable care of him; and why should it make any difference if he does not pay them directly, but only indirectly through the rates which he pays to the local authority or through insurance contributions which he makes in order to get the treatment?’

⁴³ Morgan (n 9) questions this analogy however finding it unconvincing. It is indeed hard to see how far this argument can be stretched.

⁴⁴ Which is exactly what happened in *Woodland* where the insurers for the independent contractors had used various means to seek to avoid liability: see P Giliker, ‘Vicarious liability, non-delegable duties and teachers: can you outsource liability for lessons? (2015) 31 PN 259.

4. The defendant has delegated to a third party some function which is an *integral part* of the positive duty which he has assumed towards the claimant and the third party has, as a result, acquired the custody/care/control in relation to the claimant.
5. The third party has been negligent not in some collateral aspect, but in the performance of the very function assumed by the defendant to him.

This test provides both a rationale and framework for the ‘assumption of responsibility’ non-delegable duty. While it might require minor adjustment to earlier cases,⁴⁵ the Sumption test is clearly one which extends beyond the educational context of *Woodland*. The express reference to patients at (point 1) indicates that, at the very least, it will impose on hospitals a non-delegable duty to ensure that a patient receives treatment administered with reasonable care and skill. It remains, however, for subsequent case-law to set out its scope and application.

4. The hospital non-delegable duty

Woodland presents a challenge for institutions which care for others. To what extent can those injured in their care now rely on the ‘assumption of responsibility’ non-delegable duty? To answer this question in the hospital context, it will be necessary to examine the roots of the hospital non-delegable duty. As will be seen below, no case had authoritatively recognised the hospital non-delegable duty prior to *Woodland*.⁴⁶ The gap it sought to fill, however, was one left by the doctrine of vicarious liability.

4.1 Tracing the origins of the hospital non-delegable duty

Prior to *Woodland*, the liability of the hospital rested on two bases: that of primary liability (demonstrating fault by the hospital or breach of contract) and that of vicarious liability (responsibility arising as an employer for the torts of its employees committed in the course of their employment).⁴⁷ The limits of these options were identified by Lord Greene MR in *Gold v Essex CC* in 1942.⁴⁸ In this case, the injured patient had received negligent treatment from a voluntary hospital (hence no contractual claim) by a radiographer. Authority at that time indicated vicarious liability would not arise for skilled hospital staff⁴⁹ and there was no evidence of fault by the hospital itself. Lord Greene MR in *Gold* refused, however, to allow such obstacles to defeat the claim. With echoes of the arguments raised in *Woodland* discussed above, his Lordship denied that there should be a distinction between the duties owed to paying and non-paying patients in a hospital:

⁴⁵ For example, the emphasis on control over the environment in *A* (n 36) was replaced by Lord Sumption with the need for an antecedent relationship: *Woodland* (n 8) para 24. The issue of control was deemed relevant only for category one cases involving inherently hazardous operations or dangers on the public highway where there is no antecedent relationship between the parties.

⁴⁶ As recognised by Lord Sumption in *Woodland* (n 8) para 16.

⁴⁷ A Grubb, J Laing and J McHale (eds), *Principles of Medical Law* (3rd edn, OUP, 2010) Ch 7, which noted at paras 7.21-7.37 that a non-delegable duty may also exist but that its status is uncertain.

⁴⁸ [1942] 2 KB 293.

⁴⁹ *Evans v Liverpool Corporation* [1906] 1 KB 160; *Hillyer v Governors of St Bartholomew's Hospital* [1909] 2 KB 820. See AL Goodhart, ‘Hospital and Trained Nurses’ (1938) 54 LQR 553.

'In the former case there is, of course, a remedy in contract, while in the latter the only remedy is in tort, but in each case the first task is to discover the extent of the obligation assumed by the person whom it is sought to make liable. Once this is discovered, it follows of necessity that the person accused of a breach of the obligation cannot escape liability because he has employed another person, whether a servant or agent, to discharge it on his behalf, and this is equally true whether or not the obligation involves the use of skill.'⁵⁰

Lord Denning (who had been counsel for the plaintiff in *Gold*) pursued this argument in the later case of *Cassidy v Ministry of Health*.⁵¹ While the majority were happy to treat the case as an ordinary case of vicarious liability – hence there was no gap to be filled – Lord Denning ventured a different view:

'... where the doctor or surgeon, be he a consultant or not, is employed and paid, not by the patient but by the hospital authorities, I am of opinion that the hospital authorities are liable for his negligence in treating the patient. It does not depend on whether the contract under which he was employed was a contract of service or a contract for services. That is a fine distinction which is sometimes of importance; but not in cases such as the present, where the hospital authorities are themselves under a duty to use care in treating the patient.'⁵²

In other words, the non-delegable duty was still needed in case of doubt of the existence of a contract of service, for example, in relation to consultants and other visiting professional staff. On this basis, whenever hospitals accepted a patient for treatment, they would have to use reasonable care and skill to treat the patient: 'Once they undertake the task, they come under a duty to use care in the doing of it, and that is so whether they do it for reward or not.'⁵³

Such dicta, however, came at a time when the doctrine of vicarious liability was expanding, notably in its interpretation of 'employees' operating under a contract of service. The majority in *Cassidy* was happy to impose liability on the hospital on the basis of vicarious liability (as indeed was the majority in *Gold*), holding that professional skill should no longer block identification of the surgeon or physician as a hospital employee for whom the hospitals would be vicariously liable. Vicarious liability would therefore, at the very least, cover all permanent staff of the hospital. More importantly in practical terms, as time moved on, health authorities ceased to take issue on the extent of their liability for treatment negligently administered and paid no regard to the precise standing of the individual administering the treatment.⁵⁴ Since 1990, the arrangements for the NHS Indemnity⁵⁵ signify that NHS institutions assume responsibility for the negligent acts and omissions of their employees and

⁵⁰ *Gold* (n 48) 301.

⁵¹ [1951] 2 KB 343.

⁵² *Ibid*, 362-363. See also the judgments of Lord Denning in *Roe v Ministry of Health* [1954] 2 QB 66, 82 and *Jones v Manchester Corporation* [1952] 2 QB 852, 869 (although both decided on other grounds by the majority of the Court of Appeal).

⁵³ *Cassidy* (n 51), 360.

⁵⁴ Brooke LJ pointed out in *Robertson v Nottingham Health Authority* [1997] 8 Med L Rev 1 that the agreement reached in 1954 between the Government and the medical defence organisations on how to apportion damages between the doctors' 'insurers' and the institution served to obscure the fact that there might, in a particular case, be joint liability based upon different breaches of duty (see HM(54)32).

⁵⁵ For the latest version, see *NHS Indemnity: Arrangements for Clinical Negligence Claims in the NHS* (2012) (<http://www.nhs.uk/claims/Documents/NHS%20Indemnity.pdf> accessed 14 April 2017).

others treating patients, regardless of the existence of a contract of employment or not.⁵⁶ This extends, for example, to agency staff. As Lord Phillips recognised in 2004,⁵⁷ '[t]here was thus no need for the courts to consider further the basis of [non-delegable duty] liability.' While a legal gap may have existed, practically it had been filled.

4.2 Reviving the hospital non-delegable duty

Yet, as noted above, non-delegable duties once created seem reluctant to fade away. Lord Browne-Wilkinson in *X (Minors) v Bedfordshire CC*⁵⁸ remarked in 1995 that it was 'established that those conducting a hospital are under a direct duty of care to those admitted as patients to the hospital.'⁵⁹ This, in his Lordship's view, imposed liability on the public authority for the negligent acts or omissions of its personnel even in the absence of a claim for vicarious liability. Again such dicta were obiter, but do indicate an ongoing judicial perception that the hospital non-delegable duty might still be needed, despite the changes mentioned above. One reason for the apparent revival of the hospital non-delegable duty in the 1990s identified by commentators is that of reform of the NHS during this period, notably with the introduction of measures which allowed for patients to be referred for treatment in the private sector.⁶⁰ While seeking to offer patients more choice and to reduce waiting lists and waiting times, patients receiving negligent treatment once again faced the possibility that the medical provider, to whom their treatment was contracted out, might not be regarded as an NHS 'employee' or fit within the existing arrangements whereby the NHS took responsibility for agency staff. Such patients would thus unwittingly find themselves having to bring an action against an independent contractor, who might or might not be fully insured.

The idea that change in the provision of NHS treatment is responsible for reviving the hospital non-delegable duty gains weight when one examines the 2004 case of *A (A Child) v Ministry of Defence*.⁶¹ Here an infant, whose father was a British serviceman stationed in Germany, had been injured by the negligence of the obstetrician in a German hospital. Before 1996 the Ministry of Defence had provided servicemen and their dependants living in Germany with hospital treatment in British military hospitals staffed by ministry employees. After 1996, the Ministry had closed its hospitals and chosen to contract with an English NHS trust for the trust to arrange for designated German hospital providers to provide secondary health care for servicemen and their dependants in German hospitals. A, who had suffered brain damage at birth as a result of the obstetrician's negligence, had been injured in June 1998. It was

⁵⁶ K Syrett, 'Institutional liability' in J Laing et al, *Principles of Medical Law* (4th edn, OUP, 2017) paras 7.118-7.122, MA Jones, *Medical Negligence* (4th edn, Sweet and Maxwell, 2008) para 9-036. See also M Brazier, 'NHS Indemnity: The implications for medical litigation' (1990) 6 PN 88.

⁵⁷ *A (A Child) v Ministry of Defence* [2004] EWCA Civ 641, [2005] QB 183, para 40. See also Grubb who notes that the hospital non-delegable duty was all but forgotten until the 1986 when it was referred to by the Court of Appeal in *Wilsher v Essex AHA* [1987] QB 730, 778 per Sir Nicholas Browne-Wilkinson again in the context of concerns as to the scope of vicarious liability (Glidewell LJ, agreeing on this point, at 775): A Grubb, 'Institutional duty: To provide a safe health care environment' [1997] Med L Rev 342, 343.

⁵⁸ [1995] 2 AC 633.

⁵⁹ *Ibid*, 740 (emphasis added). Applied in *Robertson v Nottingham Health Authority* [1997] 8 Med LR 1, 13.

⁶⁰ J Beswick, 'A first class service? Setting the standard of care for the contemporary NHS' (2007) 15 Med L Rev 245; K Barker, 'NHS Contracting: Shadows in the law of tort' (1995) 3 Med L Rev 161. See also M Brazier and J Beswick, 'Who's caring for me?' (2006) 7 Medical Law International 183, who again place the non-delegable duty in the context of an NHS where more and more services are contracted out and, most recently, M Brazier and E Cave, *Medicine, Patients and the Law* (6th edn, Manchester UP, 2016) paras 8.5-8.6.

⁶¹ [2004] EWCA Civ 641, [2005] QB 183.

accepted at trial that the changes introduced by the MoD for medical provision meant that it could no longer be held vicariously liable. Bar suing in Germany,⁶² the only option left in the English courts would be to raise the possibility of a non-delegable duty owed by the MoD to the patient which has been 'delegated' to the German doctors.

A, therefore, brings the hospital non-delegable duty to the fore: with vicarious liability gone and no contractual rights or evidence of fault by the MoD, would the Court of Appeal finally rely on (and acknowledge) the *Cassidy* non-delegable duty? The claim failed, but the Court did not dismiss the hospital non-delegable duty out of hand. The action was unsuccessful because, in the circumstances, the hospital treatment had not been provided by the army and they had merely *arranged* for cover for personnel overseas. The MoD, in other words, had not assumed personal responsibility for the treatment which could be said to be 'delegated' to the German hospital. Lord Phillips MR, giving the leading judgment, nevertheless accepted that there were strong arguments of policy for holding that a hospital, which offers treatment to a patient, should be regarded as accepting responsibility for the care with which that treatment is administered, regardless of the status of the person employed or engaged to deliver the treatment.⁶³ This would impose on hospitals a *duty to ensure* that the treatment administered by the hospital to the patient *is administered with reasonable skill and care*.

In the later case of *Farraj v King's Healthcare NHS Trust*⁶⁴ the claimant again was forced to rely on the non-delegable duty argument to circumvent the limitations of vicarious liability. In this case, the defendant health authority had sent samples of the claimant's blood to an independent contractor for testing, which had allegedly been undertaken negligently. As Nayer has indicated,⁶⁵ this is not an uncommon occurrence in that private laboratories are commonly used by the NHS and there is no obligation to ensure that they are insured. Nevertheless, the Court of Appeal rejected the claim for breach of a non-delegable duty on that basis that the hospital had merely provided diagnostic services and, importantly, had used the laboratory to test a tissue sample for a patient *who was not being treated by the hospital* (the patient in question was, in fact, receiving treatment in Amman). The Court found a significant difference between treating a patient who had been admitted to hospital for tests and organising tests on samples which had been provided by a person who was not a patient.⁶⁶ Again without deciding on the existence and content of the hospital non-delegable duty, Dyson LJ did conclude that:

'[p]atients are a vulnerable class of persons who place themselves in the care and under the control of a hospital ... as a result, the hospital assumes a particular responsibility for their well-being and safety. To use the language of *Caparo Industries plc v Dickman* [1990] 2 AC 605, 618 it is therefore fair

⁶² While the evidence suggested that a claim could probably have been brought successfully in Germany, the parents were British and preferred to sue in the English courts rather than face the difficulties (and costs) of bringing a claim in a foreign jurisdiction.

⁶³ A (n 61) para 63, remarking that Lord Browne Wilkinson in *X v Bedfordshire* had proceeded on the premise that this is established English law.

⁶⁴ [2009] EWCA Civ 1203, [2010] 1 WLR 2139 (non-delegable duty assumed without deciding). See R Heywood, 'Non-delegable duties and hospitals' (2010) 26 PN 49.

⁶⁵ See R Nayer, 'Outsourcing genetic and diagnostic services: a consideration of the principles for establishing a hospital's non-delegable duty and why it matters' [2011] 2 JPIL 61.

⁶⁶ *Farraj* (n 64) para 92 per Dyson LJ.

just and reasonable that a hospital should owe such a duty of care to its patients in these circumstances.⁶⁷

Farraj left open, however, the question whether an NHS patient who undergoes tests organised by the hospital treating her could assert that she is owed a non-delegable duty by the hospital.⁶⁸

While the claimants in *A* and *Farraj* were unsuccessful, these cases are important in highlighting that, in the modern NHS, situations may arise where, despite policy decisions not to distinguish between different types of staff and the growth of vicarious liability, the flexibility of the non-delegable duty might still be needed. Further they demonstrate judicial recognition of an emerging legal framework for the non-delegable duty based on the undertaking of care, supervision and control of persons who, as patients, were in special need of care, even if, in both cases, the claim for the non-delegable duty failed. These cases – with their reference to Australian law – are part of the path towards the *Woodland* ‘assumption of responsibility’ non-delegable duty. We can note recognition of the role of policy and, what is interesting for this article, express acknowledgement in *Farraj* of parallels between the revival of the hospital non-delegable duty and the three-part *Caparo* test where the duty of care in negligence arises not only where harm is foreseeable, but where there is proximity and its imposition would be fair, just and reasonable. One question remains: how will this non-delegable duty operate post-*Woodland*?

5. Applying the *Woodland* ‘assumption of responsibility’ test to hospitals: When will liability be fair, just and reasonable?

From the perspective of hospitals, *Woodland* marks the coming of age of *Cassidy* with Lord Denning’s non-delegable duty finally accepted into the legal mainstream. We are now at a stage when we can say with confidence that the hospital non-delegable duty exists and will form part of the armoury of the courts in dealing with clinical negligence claims. It is conceptually distinct from vicarious liability and indeed other forms of primary liability of hospitals (e.g. a duty to use reasonable care to provide access to hospital care and an organisational duty to use reasonable care to ensure that the hospital staff, facilities and organisation provided are those appropriate to provide a safe and satisfactory medical service for the patient).⁶⁹ It arises due to a perceived gap in the cover provided by these options due to the rise in out-sourcing and increased use of agency staff where, despite the growth of the parameters of vicarious liability and the generous NHS Indemnity provisions, there is still a sense that these measures are not sufficient to cover all meritorious claims by patients.

Such liability is not, however, without limits. Lord Sumption made it perfectly clear that the imposition of the ‘assumption of responsibility’ non-delegable duty would be exceptional and

⁶⁷ *Ibid*, para 88.

⁶⁸ See J Beswick, ‘A Brave New Bolam’ (unpublished PhD thesis, University of Manchester, 2012) 189, who argues that this is a duty the courts should insist on. <https://www.escholar.manchester.ac.uk/uk-ac-man-scw:166456> accessed 14 April 2017. Consider *S v Lothian Health Board* [2009] CSOH 97, 2009 SLT 689 (test for cystic fibrosis undertaken by researchers but at invitation of hospital treating mother).

⁶⁹ See Syrett (n 56) para 7.37 ff; *Clerk and Lindsell on Torts* (n 12) para 10-93; Jones (n 56) para 9-016 ff; *A* (n 61) para 32 per Lord Phillips MR.

that 'the main problem about this area of law is to prevent the exception from eating up the rule'.⁷⁰ In common with vicarious liability, non-delegable duties are inconsistent with the primacy of fault-based liability in tort, and thus only justifiable when they are the 'appropriate response to a given level of risk'.⁷¹ Liability should arise, therefore, when it was fair, just and reasonable to do so and, in applying this test, Lord Sumption advised that the courts should be sensitive about imposing unreasonable financial burdens on those providing critical public services.⁷²

This leaves us with two control mechanisms determining when liability should arise: (i) the Sumption five-fold test and (ii) the fair, just and reasonable test. The application of these tests to hospital cases will be examined in more detail below.

5.1 Applying the Sumption five-fold test to hospitals

The Sumption test set out above is superficially clear. If I am a patient in a hospital who requires a heart-bypass operation, then it should not matter who actually performs the operation if I decide to sue the hospital for negligence. Yet once we examine the test in more detail, potential difficulties arise. The non-delegable duty extends only to treatment which is integral to the hospital's duties (point 4); it excludes collateral negligence (point 5); and it only arises where there is a pre-existing relationship between the patient and the hospital which places the patient in the actual custody of the hospital (point 2). Identifying the 'integral' functions of the hospital, we would logically include matters such as the performance of operations and the provision of medicines. Excluded would be 'non-inherent' functions such as organising a social outing for patients or, arguably, arranging a taxi to take the patient home.⁷³ Yet, other sources of negligence arising from out-sourced work are not necessarily as clear-cut. Consider, for example, whether the duty should extend to the negligence of hospital caterers, hospital cleaners or even the hapless volunteer librarian who drops a great tome on the patient's broken leg. What of the window cleaner who drops his bucket injuring a patient taking exercise in the hospital grounds? Are any of the above 'integral' to hospital care?

Further concerns may be raised. Reliance on 'collateral negligence' to limit claims is problematic in itself in that this is a term which is notoriously vague⁷⁴ and for which there are very few authorities.⁷⁵ It is unlikely, therefore, to act as an effective brake on claims. The non-delegable duty will also only arise, under point 2, where the defendant hospital has undertaken to provide treatment to a specific patient and the patient is placed in the actual

⁷⁰ *Woodland* (n 8) para 22.

⁷¹ *Ibid.*

⁷² *Ibid.*, para 25.

⁷³ Consider *Myton v Woods* (1980) 79 LGR 28 (local education authority only had a duty to make reasonable arrangements for the transport of the children to and from school. It did not extend to a duty to ensure that reasonable care had been taken by the taxi company in question). Note also *Darnley v Croydon Health Services NHS Trust* [2017] EWCA Civ 151: there is no general duty upon civilian hospital receptionists to keep patients informed about likely waiting times.

⁷⁴ See P Giliker, 'Vicarious liability' in K Oliphant (ed), *The Law of Torts* (3rd edn, LexisNexis, 2015) paras 3.59-3.60.

⁷⁵ See Sachs LJ in *Salsbury v Woodland* [1970] 1 QB 324 at 348.

care and control of the hospital in circumstances where it is possible to impute the assumption of a positive duty to protect the claimant from harm. On this basis, a non-delegable duty did not arise in *A* where the MoD had arranged for the provision of treatment in the German hospital and it had not been provided by the MoD itself. *Woodland* thus draws a fundamental distinction between the caring duties *undertaken* by the defendant towards the patient (for which the hospital assumes a positive duty of responsibility) and matters which the defendant *arranges* on the patient's behalf.⁷⁶ This raises, however, questions of interpretation. Are ante-natal tests on the foetus by a specialist laboratory *undertaken or arranged* by the hospital treating the patient? Such issues become vital in cases such as *Farraj* and were considered in the Scottish case of *S v Lothian Health Board*.⁷⁷ In *S*, an action was brought against the local health board when the hospital had invited the claimant to undergo a test which would be undertaken by an independent team of university researchers. The claimant alleged that the test was undertaken negligently and sought to hold the hospital liable. The Outer House was prepared to accept that, where the hospital had not made it clear to the patient that the test would be undertaken by independent researchers, it could be argued that the hospital had assumed responsibility to her for the tests. *Lothian* indicates the difficult interpretative issues which can arise from the undertaken/arrange distinction.

Tettenborn has also questioned the 'lack of control' element of the test.⁷⁸ Under point 3 of the Sumption test, the claimant must have no control how the defendant chooses to perform its obligations. Yet, as Tettenborn indicates, patients, unlike schoolchildren, do have an element of control in who performs their treatment. The NHS Choice Framework gives patients the right to choose GPs, consultants or specialists in the course of their treatment.⁷⁹ While logically we must follow the advice of Lady Hale in *Woodland* that the Sumption test is not be treated as if it were a statute set in stone,⁸⁰ this query highlights the difficulties of applying a generic test to patients and children alike. It cannot have been the intent of the court to exclude patients exercising their rights of choice under the modern NHS from the hospital non-delegable duty.

Nevertheless, on a more theoretical level, two further questions arise - one general and one specific to clinical negligence. The first relates to the basis for the Sumption test itself. Liability under the test is justified by the fact that the institution is deemed to have assumed responsibility for the care of the claimant. Liability will thus arise, as point 2 of the Sumption test makes clear, when 'it is possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm', that is, an objective assumption of responsibility arises when the school, hospital etc undertakes the 'task' of dealing with the claimant in the knowledge that the claimant will generally rely on it for protection against harm.⁸¹ This version of the 'assumption of responsibility' argument has, however, been subject to

⁷⁶ See also Giliker (n 44) and R George, 'Non-delegable duties of care in tort' (2014) 130 LQR 534, 536-7.

⁷⁷ [2009] CSOH 97, 2009 SLT 689.

⁷⁸ *Clerk and Lindsell on Torts* (n 12) at para 10-95.

⁷⁹ See Syrett (n 56) para 7.36. For example, you have a legal right to choose a consultant-led team if you are referred to a specialist, as long as that team provides the treatment you require: see, generally, <http://www.nhs.uk/NHSEngland/patient-choice/Pages/your-rights-to-choice.aspx> accessed 14 April 2017.

⁸⁰ *Woodland* (n 8) at para 38.

⁸¹ What Barker has termed the 'weak' version of the assumption of responsibility argument which, unlike the strong version, is not based on implied agreement to be legally responsible: see K Barker, 'Wielding Occam's Razor: Pruning strategies for economic loss' (2006) 26 OJLS 289.

considerable judicial and academic criticism, not least by Keith Stanton in his work. Stanton has described the ‘assumption of responsibility’ concept as ‘a very attractive way of summarising a result’, adding that ‘it has very limited utility as a mechanism to assist in reaching that result.’⁸² He is not alone in his critique, Robertson and Wang arguing recently that the concept is simply a means of determining (in the manner of the neighbour principle) what obligation can fairly be imposed on the defendant in the circumstances and hence adds nothing of relevance to the Sumption test.⁸³ Judges, Stanton argues, are seeking the ‘best result’ and using both the ‘assumption of responsibility’ and ‘fair just and reasonable’ tests as a basis to justify a conclusion when they should be providing a test which assists in reaching that conclusion. While Stanton’s work is directed at the ‘duty of care’ test for negligence, I would argue that it is helpful also in the non-delegable duty context and raises clear concerns as to the legitimacy of the ‘assumption of responsibility’ justification for the *Woodland* non-delegable duty.

The second question relates to the Sumption test in the wider context of clinical negligence. The test relies upon the paradigm of the vulnerable patient dependent on the hospital to decide on her treatment. This image, however, is one which conflicts with that seen in other areas of medical negligence law. In *Montgomery v Lanarkshire Health Board*,⁸⁴ for example, the Supreme Court envisaged the patient as one holding rights and exercising choices rather than a passive recipient of the care of the medical profession.⁸⁵ The image is that of the patient as a consumer and autonomous human being. *Montgomery* then assumes that patients *are* capable of processing information and making decisions as to treatment, although doctors should take into account their particular needs, concerns and circumstances as patients to the extent that they are or ought to be known to the doctor.⁸⁶ In this light, the hospital non-delegable duty is based on a generalisation – that all patients are inherently vulnerable due to their dependence on the hospital for their care. This ignores the obvious difference between, for example, an adult patient admitted for an ingrowing toe-nail and one admitted for open-heart surgery. *Woodland* makes no attempt to reconcile these two images of the patient – one recognising patient autonomy, the other paternalistic. While we might regard school pupils as inherently vulnerable, can the same be said about all hospital patients? If not, then the very analogy that underpins *Woodland* – that of school pupil and hospital patient – is undermined.

⁸² ‘Professional negligence: Duty of care methodology in the twenty first century’ (2006) 22 PN 134, 138. See also K Stanton, ‘Assumption of responsibility, negligence and freezing orders’ [2006] LMCLQ 160, 162: ‘a flawed concept’. For the classic criticism of assumption of responsibility, see K Barker, ‘Unreliable Assumptions in the Modern Law of Negligence’ (1993) 109 LQR 461. For judicial criticism, see *Smith v Eric S Bush* [1991] 1 AC 831, 862 per Lord Griffiths, *Caparo v Dickman* [1990] 2 AC 605, 628 per Lord Roskill, *Phelps v Hillingdon LBC* [2001] 2 AC 619, 654 per Lord Slynn.

⁸³ A Robertson and J Wang, ‘The assumption of responsibility’ in K Barker, R Grantham and W Swain (eds), *The Law of Misstatements: 50 Year on from Hedley Byrne v Heller* (Hart, 2015) 58-59. In what sense they ask did the school in *Woodland* choose to teach a pupil it was required to educate under the Education Act 1996?

⁸⁴ [2015] UKSC 11, [2015] AC 1430. See R Bagshaw, ‘Modernising the doctor’s duty to disclose risks of treatment’ (2016) 132 LQR 182.

⁸⁵ ‘The social and legal developments which we have mentioned point away from a model of the relationship between the doctor and the patient based on medical paternalism ... What they point towards is an approach to the law which, instead of treating patients as placing themselves in the hands of their doctors (and then being prone to sue their doctors in the event of a disappointing outcome), treats them so far as possible as adults’: *Montgomery* (n 84) para 81.

⁸⁶ *Ibid*, para 73. See also *Webster v Burton Hospitals NHS Foundation Trust* [2017] EWCA Civ 62, paras 26-31.

The above analysis indicates that the application of the ‘assumption of responsibility’ non-delegable duty in the hospital context will give rise to difficulties in theory and in practice. There is, however, a further matter to consider: to what extent will the ‘fair, just and reasonable’ test act as a further barrier to recovery?

5.2 When is it fair, just and reasonable to impute an assumption of responsibility?

The test of ‘fair, just and reasonable’ is one which is familiar to common lawyers as part of the three-fold *Caparo* test. It permits the courts to determine the imposition of duties of care with reference to policy.⁸⁷ Unsurprisingly it is an approach which divides commentators. For Stevens, it is unacceptable: it is for Parliament to address policy arguments and such a test, he argues, grants judges unwarranted power in circumstances where they lack the political and technical competence to weigh competing policy claims.⁸⁸ For others, while such a test undoubtedly leads to legal uncertainty, this is regarded as inevitable and a price worth paying in order to enable the law to develop an abstract synthesizing strategy towards the duty of care concept.⁸⁹ Ultimately much depends on how comfortable we are with uncertainty. For Keith Stanton, the concepts of ‘foreseeability’, ‘proximity’ and ‘fair, just and reasonable’, as used in *Caparo*, are inherently vague, giving judges ‘limited concrete guidance and considerable discretion.’⁹⁰ In his 2006 JPN article, ‘Professional negligence: Duty of care methodology in the twenty first century’,⁹¹ Stanton explains why this is a problem: it will require a case by case approach which is likely to lead to ‘pockets’ of liability as the courts determine when it will arise and to what extent. Laws LJ in the Court of Appeal in *Woodland* shared similar concerns. The *Caparo* fair, just and reasonable test, he argued, ‘is very general and broad-based; it offers, with great respect, little guidance for a principled enquiry whether the court should accept the suggested step beyond the paradigm. An altogether sharper edge is needed.’⁹² This, he argued, required narrowing the scope of liability and could be found in the special position of a schoolchild, analogous to that of a hospital patient, who is receiving a service which is part of the institution's mainstream function of education or tending to the sick. In other words, Laws LJ relied on his version of the Sumption test to reduce the scope (and uncertainty) of the *Caparo* ‘fair, just and reasonable’ test.

In contrast, the Court of Appeal in *NA v Nottinghamshire CC*⁹³ treated the test as one which *supplements* the Sumption test. For Black LJ, the five elements of the Sumption test ‘should

⁸⁷ See A Beever, *Rediscovering the Law of Negligence* (Hart Publishing, 2007) 187: the test is ‘code for policy’.

⁸⁸ R Stevens, *Torts and Rights* (OUP 2007) 308-310.

⁸⁹ See, for example, Barker who argues that this is not a weakness but simply how concepts as organising tools operate: Barker (n 81) 301.

⁹⁰ Stanton (n 82) at 136. Oliphant has also warned that reliance on policy can only be speculative and intuitive, rendering the law unpredictable without concern for principle or coherence: K Oliphant, ‘Against certainty in tort law’ in SGA Pitel, JW Neyers, E Chamberlain, *Tort Law: Challenging Orthodoxy* (Hart, 2013) 8.

⁹¹ Stanton (n 82). See also KM Stanton, ‘Decision-making in the tort of negligence in the House of Lords’ (2007) 15 Tort L Rev 93; KM Stanton ‘The neighbour principle in the 21st century: Yesterday’s revolution’ (2012) 20 Tort L Rev 61.

⁹² [2012] EWCA Civ 239, [2014] AC 537, para 9. See also para 25.

⁹³ [2015] EWCA Civ 1139, [2016] QB 739. See P Morgan, ‘Fostering, vicarious liability, non-delegable duties, and intentional torts’ (2016) 132 LQR 399.

not be undertaken in a limbo⁹⁴ and, therefore, even where all five elements are satisfied, there may be reasons, as Lord Sumption suggested, arising from concerns about imposing unreasonable financial burdens on public authorities which render liability unacceptable. In *NA* itself, both the Court of Appeal and the High Court were influenced by policy reasons varying from diversion of financial resources to a fear of defensive risk-averse practices.⁹⁵ This overt introduction of policy concerns, in addition to the interpretative difficulties in applying the Sumption test to the hospital context, must be a matter of concern, notably at a time when we are informed that the NHS is currently suffering a financial crisis.⁹⁶ To what extent, therefore, will such financial considerations render it more difficult for patients who have satisfied the Sumption test to obtain compensation under the hospital non-delegable duty?

5.3 Other concerns: Intentional torts?

*NA v Nottinghamshire CC*⁹⁷ raises a further question: would the hospital non-delegable duty extend to intentional misconduct, for example, the rape of a patient by a porter where such services had been contracted out to be a firm of independent contractors? Assuming the porter cannot be deemed 'akin to an employee' and that any such tort would not be 'in the course of his employment',⁹⁸ would the hospital non-delegable duty apply? Lord Sumption spoke only of negligence in *Woodland*, but this was the context of the cases on which he built his test. The Court of Appeal in *NA* found the question less than straightforward. For Burnett LJ, the authority for such non-delegable duties was based on negligence, not on intentional torts, and there was no authority to support its application in the latter context.⁹⁹ In contrast, Black LJ saw no reason why the test should not extend to intentional wrongs,¹⁰⁰ but, in applying the fair, just and reasonableness test, did argue that extending the duty to intentional torts would place an unreasonable burden on the local authority and would be contrary to the best interests of children in care.¹⁰¹ Subject to guidance from the Supreme Court, therefore, at this point we can only conclude even if the non-delegable duty extends to intentional misconduct it is likely be more difficult to establish liability.

⁹⁴ *Ibid*, para 60.

⁹⁵ [2015] EWCA Civ 1139, para 25 per Tomlinson LJ; para 38 per Burnett LJ and paras 60-65 per Black LJ; [2014] EWHC 4005 (QB), paras 198-210 per Males J.

⁹⁶ See, for example, D Campbell, 'Demand for NHS care is dangerously high' *The Guardian* 8 September 2016, D Campbell and S Marsh, 'NHS crisis: 20 hospitals declare black alert as patient safety no longer assured' *The Guardian* 7 January 2017.

⁹⁷ [2015] EWCA Civ 1139.

⁹⁸ See, for example, *X v Kuoni Travel Ltd* [2016] EWHC 3090 (QB); *XVW v Gravesend Grammar Schools for Girls* [2012] EWHC 575 (QB), [2012] ELR 417.

⁹⁹ *NA* (n 97) para 37, relying on the Australian decision in *NSW v Lepore* (2003) 212 CLR 511.

¹⁰⁰ Tomlinson LJ expressed no view on this point: *NA* (n 97) para 26.

¹⁰¹ *Ibid*, paras 60-65.

5.4 Applying the hospital non-delegable duty in relation to medical treatment in an immigration centre

Faced with limited post-*Woodland* authority, the decision of the High Court in *GB v Home Office*¹⁰² is helpful in giving some indication how the courts are likely to respond to the tests discussed above. Here the Court found that the Home Office did owe a non-delegable duty of care to an immigration centre detainee arising out of medical treatment administered to her while in detention. The detention centre in question had been contracted out to a private provider, Serco. The administration of drug treatment to the detainee arose directly out of the Home Office's detention and was found to be an integral part of the positive duty it assumed towards her, notwithstanding that the performance of that duty had been delegated to an agency. Such a duty was fair, just and reasonable because detainees in immigration detention were inherently vulnerable and highly dependent on the observance of proper standards of care.

The reasoning of Coulson J reflects some of the difficulties noted above. The judge recognised the problems of applying point 4 of the Sumption test: did the Home Office delegate to a third party some function which is an *integral part* of the positive duty towards the claimant? Here the claimant had not been placed in detention to receive medical services, but the judge nevertheless concluded that the provision of medical care was an integral part of the positive duty owed by the defendant to GB.¹⁰³ This has to be correct – prisons and immigration centres cannot simply argue that they are not required to care for the physical or mental conditions of their prisoners. Interesting also is the judge's analysis of the fair, just and reasonable test. Coulson J placed emphasis on arguments that out-sourcing should not make a difference to claimants, the vulnerability of detainees and the difficulties in bringing a claim otherwise, that is, issues which are victim-centred. Significantly he added:

'It is also worth undertaking something of a reality check at this point. The defendant decided to detain GB, and consequently had clear responsibilities for her treatment as a detainee as a result. It would not be just, fair or reasonable to conclude that those responsibilities disappeared simply because of an outsourcing decision.'¹⁰⁴

What is missing here, of course, is the consideration that the courts should be sensitive about imposing unreasonable financial burdens on those providing critical public services. How much will such liability potentially cost the Home Office? How will a court be able to assess such matters if they are not pleaded by counsel? Can this be argued if/when the case proceeds to trial?¹⁰⁵ Fundamentally, does *GB* reflect the 'exceptional' approach envisaged by Lord Sumption?

6. Conclusions

In *Woodland* the Supreme Court indicated its willingness to recognise the existence of a protective non-delegable duty of care, which would ensure the welfare of 'vulnerable'

¹⁰² [2015] EWHC 819 (QB) (a striking out decision).

¹⁰³ *Ibid*, para 34.

¹⁰⁴ *Ibid*, para 43.

¹⁰⁵ The case was argued on a preliminary issue.

claimants placed in the care or custody of public institutions. In so doing, the Court drew on authority supporting the hospital non-delegable duty and justified intervention by reference to the problems arising from institutional out-sourcing and the risk of discrimination between those in the private and public sector. Non-delegable duties exist to fill a gap in existing legal cover and the perception is that such a gap exists in the educational sphere (as seen in *Woodland* itself) and due to changes in the provision of medical treatment (as shown in *A and Farraj*).

This article has highlighted a number of areas of concern. First of all, the Sumption test, despite its five elements, is guilty of generalisations and has yet to be applied specifically in the context of hospital provision. Difficulties in interpretation remain to be ironed out in practice and its theoretical foundations have been questioned. Secondly, this test is supplemented by the 'fair just and reasonable' test. This adds an extra level of uncertainty and this article has highlighted how the critique of Stanton concerning the duty of care test throws additional light on the operation of this concept in the non-delegable duty context. It remains to be seen whether courts will target financial concerns (as suggested in *Woodland* to ensure that liability remains 'exceptional') or will focus more on the victim-centred concerns (as seen in *GB*) in determining the scope of this duty.

To conclude, therefore, the law in this area, despite the intervention of the UK Supreme Court, remains in a rather uncertain state. The application of the Sumption and 'fair just and reasonable' tests are subject to criticism and the very justification for the non-delegable duty appears to be a matter of dispute at the very least. We might argue, however, that *Woodland* concerned more fundamental issues – there was a gap in the law to be filled and, whatever the legal niceties scholars (and even judges) may raise, the Supreme Court did exactly that. In reviving the non-delegable duty in the context of the institutional liability of hospitals, the courts were responding to changes in practice in the modern NHS. However, in the hospital context, it is submitted, more reflection is needed. The liability of hospitals to patients has been transformed by the expansion of vicarious liability and by the arrangements for the NHS indemnity outlined above. This raises the question – albeit one which the Supreme Court did not have to address in *Woodland* – which is whether issues such as outsourcing *have* created a gap which needs to be filled or merely the *perception of a gap to be filled*. It is of interest that leading medical law text *Mason and McCall Smith's Law and Medical Ethics* gives *Woodland* a cautious welcome;¹⁰⁶ the authors arguing that the breadth of the vicarious liability doctrine (covering doctors, nurses etc) is such that the hospital non-delegable duty will only be argued in cases where contracted staff are used whose group or personal insurance may be 'less comprehensive than is that of the professions.'¹⁰⁷ Equally, the view of the NHS Litigation Authority (now NHS Resolution)¹⁰⁸ is that while *Woodland* is significant as a result of the NHS increasingly using private sector providers to deliver NHS care, it will not

¹⁰⁶ G Laurie et al, *Mason and McCall Smith's Law and Medical Ethics* (10th edn, OUP, 2016) para 5.24.

¹⁰⁷ *Ibid* See also Jones (n 56) who argues that the non-delegable duty will only be argued when the medical professional in question has no or limited insurance cover and Brazier and Cave (n 61) at 8.6 who make a similar point.

¹⁰⁸ The NHS Litigation Authority (NHSLA) handles negligence claims and works to improve risk management practices in the NHS. In April 2017 the NHSLA changed its name to NHS Resolution and launched a five year strategy underpinning the change.

change the position of Clinical Commissioning Groups (who arrange, but do not undertake secondary care)¹⁰⁹ and will have limited impact on hospitals. It also notes that since April 2013, private providers of NHS healthcare have been entitled to join the NHSLA clinical negligence scheme in their own right and over 50 have already done so.¹¹⁰

In determining, therefore, how far victims will be able to rely on the non-delegable duty for compensation, *Woodland* poses rather than answers the question. This article has focussed on hospital liability but the concerns raised are equally applicable in any institutional context in which the 'assumption of responsibility' non-delegable duty is raised. As Sedley LJ warned in *Farraj*, the imposition of a non-delegable duty involves 'peculiar considerations of policy and law' which signifies that 'caution is needed in importing the palliative concept of the non-delegable duty into other legal relationships.'¹¹¹ For the moment, it remains to be seen how *Woodland* will fare in the specific context of claims relating to hospital treatment and to what extent concerns relating to the cash-strapped NHS and broader issues such as defensive medicine may render the hospital non-delegable duty of limited practical utility to injured patients.

¹⁰⁹ For a contrary view, see Brazier and Cave (n 61) para 8.6.

¹¹⁰ *NHSLA Annual Review – Supporting the NHS 2013-/14* (NHSLA, 2014) at 29. See <http://www.nhsla.com/AboutUs/Pages/AnnualReport.aspx> accessed 14 April 2017.

¹¹¹ *Farraj v King's Healthcare NHS Trust* [2009] EWCA Civ 1203, para 103.